

CHAPTER

5

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY (ICF/IID) LEVEL OF CARE

To enroll in the ID/RD Waiver a potential participant must:

1. be diagnosed with an intellectual disability or a related disability (as determined by SCDDSN),
2. be eligible to receive Medicaid,
3. be allocated a waiver slot,
4. choose to receive services in his/her home and community and
5. meet ICF/IID Level of Care.

A person does not have to be currently served by SCDDSN to request a waiver slot.

Initial ICF/IID Level of Care Evaluations for the Purpose of Enrolling in the ID/RD Waiver:

The Consumer Assessment Team makes the initial determination of ICF/IID Level of Care. The Service Coordinator/Early Interventionist (SC/EI) must send a Request for ICF/IID Level of Care (ID/RD Form 9) to the Consumer Assessment Team after the following have been met:

1. a waiver slot has been allocated,
2. feasible alternatives under the waiver have been explained to the consumer,
3. and the consumer has been given a choice of institutional services or home and community-based services,

In addition to ID/RD Form 9, the SC/EI must forward records that support the Level of Care. These records may include:

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores that support a diagnosis of an intellectual disability or a related disability. Every effort should be made to locate the report that is noted on the consumer's Eligibility Letter as well as any additional current evaluation reports, if applicable.

If the consumer does not have an intellectual disability and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be, for example, a report from the SCDDSN Autism Division, or appropriate medical, genetic or adaptive assessments. The SCDDSN Eligibility letter should always be included for those consumers who have a related disability. If the Eligibility Letter cannot be located, a printout of the SCDDSN Eligibility History on CDSS will suffice.

2. Current Support Plan, SC Annual Assessment, Individualized Family Service Plan, IEP or Family Service Plan.
3. Any/all other current (within one year) signed and dated information pertaining to:
 - Daily living and other adaptive functioning
 - Behavior/emotional functioning (e.g. Behavior Support Plan)

- Medical and related health needs.

If the consumer is a child receiving EI through BabyNet (i.e., not DDSN eligible), or is served by DDSN as a High-Risk Infant or At-Risk Child, the following support documentation must be included in the packet:

- A SCDDSN Eligibility Letter (if applicable)
- A current (within 3 months) screening assessment
- All available relevant medical, genetic and developmental reports. This may include historical as well as current information

If the consumer is served through the Head and Spinal Cord Injury (HASCI) Division, all available current and prior school records, including transcripts, IEP's and psychological reports, as well as supportive medical documents, must be included with the request for Level of Care.

The needed information should be mailed to the Consumer Assessment Team at the following address:

8301 Farrow Road
Columbia, SC 29203-3294

After file review, the Consumer Assessment Team may return the request to the SC/EI and request that the potential waiver participant be tested by a SCDDSN-approved psychologist. The Consumer Assessment Team may also request additional records or reports prior to completing the Level of Care Determination.

If an ID/RD Waiver slot has been allocated and the Level of Care Determination is requested at the same time as a request for a determination of eligibility for services, the eligibility determination will be completed first. In this case, duplicate packets should be sent to the Consumer Assessment Team, each with a cover sheet. One packet's cover sheet should indicate that the packet is designated for the eligibility determination, while the other packet's cover sheet should indicate that the packet is designated for the Level of Care determination.

Note: The SCDDSN Consumer Assessment Team has the discretion to request that a consumer's current eligibility be re-evaluated prior to completion of a Level of Care determination if, after file review, there is a question as to whether or not the consumer's current eligibility category is appropriate.

Once all needed information is received, the Consumer Assessment Team will review the information and complete all sections of the Level of Care Determination for ICF/IID. To be valid, all items on the form must be completed. The Consumer Assessment Team should render a decision regarding Level of Care within ten (10) days of receipt of the Request for ICF/IID Level of Care (ID/RD Form 9) and all needed information.

When the Level of Care determination has been made, the Consumer Assessment Team will certify that the person does or does not meet ICF/IID Level of Care. This is done by completing the SCDDSN Level of Care Certification Letter and mailing the completed letter, with the procedure for appeals, to the applicant/legal guardian and a copy to the SC/EI. The Consumer Assessment Team is also responsible for providing the SCDDSN Waiver Enrollment Coordinator with the Level of Care information needed for enrollment. In addition to the Certification Letter, the SC/EI will receive the Level of Care Determination for ICF/IID and the Level of Care Staffing Report (ID/RD Form 7) that have been used by the Consumer Assessment Team to determine whether or not ICF/IID Level of Care was met. **These forms, along with the Certification Letter, must be kept in the applicant's file and never be purged.**

Consumers Who Do Not Get Enrolled within 30 days of the Initial Level of Care Determination:

Waiver enrollment must occur within thirty (30) days of the Level of Care Determination date (see Chapter 6 Enrollments for more specific information). If the applicant's Level of Care Determination was completed thirty (30) or more days prior to waiver enrollment, a new SCDDSN Certification Letter must be issued. If a waiver applicant's Level of Care has expired prior to enrollment in the ID/RD Waiver, **a re-certification does not have to be done immediately.** As long as enrollment occurs within 180 days of the initial Level of Care, it may be re-certified once all enrollment issues have been resolved. **Note: If more than 180 days have passed since completion of the initial Level of Care Determination, then a new Level of Care Determination (by the Consumer Assessment Team) is required prior to enrollment.**

The SC/EI should take the following steps for ID/RD Level of Care re-certification:

1. Contact the Waiver Enrollment Coordinator when a Level of Care nears expiration or has already exceeded thirty days.

Note: If the Waiver Enrollments Coordinator has completed all paperwork regarding the enrollment, and the request has been submitted to DHHS, there is no need to re-certify the Level of Care. This may be determined by checking the enrollment status on the Waiver Tracking system under ENINS. If the enrollment status is "awaiting," then the request has already been submitted to DHHS, and re-certification is not required.

2. Upon receipt of verification from the Waiver Enrollment Coordinator that all enrollment information is completed, request re-certification of the Level of Care. If the case is not ready for enrollment, the Waiver Enrollment Coordinator will make contact when the Level of Care needs to be re-certified.

Note: Prior to requesting the re-certification from the Consumer Assessment Team, the SC/EI must verify that the participant's condition has not changed since completion of the initial Level of Care Determination. To do so, he/she should:

- Review the Level of Care Determination for ICF/IID form and the supporting documentation upon which the initial Level of Care was completed.
 - Determine if the record contains more current reports or other information that might impact the answer to each specific question on the Level of Care Determination Form.
 - Contact the applicant/legal guardian to verify the current status of the applicant and that his/her condition has not changed to the extent that it would likely change the Level of Care decision. **This must be clearly documented in the applicant's file and in a notation to the Consumer Assessment Team.**
3. If **the applicant's condition has not changed**, contact the Consumer Assessment Team via telephone, and request a Level of Care re-certification. Resubmit, via fax, a new Request for ICF/IID Level of Care (ID/RD Form 9) – indicate on the form that it is an initial LOC (expired) and enrollment did not occur within 30 days of the LOC effective date – along with the initial Level of Care Determination for ICF/IID form, the Certification Letter and a request for issuance of a new Certification Letter. Indicate on the fax cover sheet that the applicant's condition has not changed and with whom that information was verified.

Note: The SC/EI must verify that the consumer is ready for enrollment by consulting with the Waiver Enrollment Coordinator (see Attachment 1 in Chapter 6) prior to contacting the Consumer Assessment Team. The Waiver Enrollment Coordinator will notify the Consumer Assessment Team via e-mail that the consumer is ready for enrollment in the ID/RD Waiver once all of the enrollment issues are resolved.

If the consumer's condition has changed, a new initial Level of Care packet must be submitted to the Consumer Assessment Team. The team should be apprised via telephone as to why this Level of Care is being requested. The SC/EI should determine what current reports or other information is needed that might impact the answer to each specific question on the Level of Care Determination form, obtain these records and add them to the original packet that was submitted to the Consumer Assessment Team. A new Request for ICF/IID Level of Care (ID/RD Form 9) must be completed.

Once the re-certification is completed by the Consumer Assessment Team, the SC/EI will receive a new Certification Letter, along with the updated Level of Care Determination for ICF/IID form. When the initial Level of Care is re-certified, the date of the re-certification becomes the **new effective date** of the Level of Care. To document that the initial Level of Care was re-certified, the Director of the Consumer Assessment Team will sign, date and notate "update" on the initial Level of Care Determination form below the signature line, and a new Level of Care Certification Letter will be completed. The Consumer Assessment Team will notify the Waiver Enrollment Coordinator of the new Level of Care date.

Once the Level of Care has been re-certified, it cannot be re-certified again. If the consumer is not enrolled in the ID/RD Waiver within thirty (30) days of the re-certification, then a new Level of Care packet must be submitted to the Consumer Assessment Team.

Note: The Consumer Assessment Team has the discretion to deny a re-certification and ask that a new initial Level of Care packet be submitted.

ICF/IID Level of Care Re-evaluations/Re-determinations for ID/RD Waiver Participants:

Once enrolled, ICF/IID Level of Care determinations are valid for up to 365 calendar days, unless otherwise stipulated by the Consumer Assessment Team, but can never be more than 365 days. Each participant must be re-evaluated at least annually (or as needed, given changes in condition, diagnosis, etc.) and re-determined to meet ICF/IID Level of Care in order to continue to receive ID/RD Waiver-funded services. The SC/EI is responsible for these annual re-evaluations and determinations **except when for those participants who are eligible on a time-limited basis. For those who are served on a time-limited basis under the eligibility categories of Intellectual Disability, Related Disability, At-Risk Child, or High-Risk Infant, the Level of Care re-evaluation must be completed by the Consumer Assessment Team. The same information required for an initial Level of Care evaluation, plus the most recent Level of Care Determination for ICF/IID and Certification Letter, must be sent to the Consumer Assessment Team.**

For all other participants, the SC/EI is responsible for the annual re-evaluation of ICF/IID Level of Care. The review will, at a minimum, consist of a review of the most recent psychological, social and medical information along with a review of the current IFSP/FSP, Support Plan, Service Coordination Annual Assessment and/or IEP. Based on the review of these and any other documents, the SC/EI must complete the Level of Care Re-Determination for ICF/IID.

Note: All items on the determination form must be scored/completed. Failure to score/complete all items will render the determination invalid. No waiver services can be authorized in the absence of a complete and valid LOC Determination.

All decisions must be reviewed by the SC/EI's Supervisor or the Executive Director of the DSN Board/Provider. All Level of Care re-evaluations must be documented, along with the review from the Supervisor or Executive Director. Once the supervisory review is complete, the Level of Care Determination for ICF/IID and the Level of Care Certification Letter (if completed) must be placed in the participant's file. **If a participant still meets ICF/IID Level of Care, the SCDDSN Level of Care Certification Letter does not have to be completed.**

If it is determined that a participant does not continue to meet ICF/IID Level of Care, the SC/EI must complete the SCDDSN Level of Care Certification Letter. All information used to make this determination along with the completed Level of Care Determination for ICF/IID and the Certification Letter must be submitted to the Consumer Assessment Team as well as a Request for ICF/IID Level of Care (ID/RD Form 9), indicating ‘found to not meet ICF/IID LOC by DSN Board/Provider.’ **These materials must be sent to the Consumer Assessment Team far enough in advance to allow them to complete the review of the determination prior to the expiration date of the current certification.** If the Consumer Assessment Team concurs with the determination that the participant does not meet ICF/IID Level of Care, the Consumer Assessment Team Director will co-sign the Level of Care Determination for ICF/IID and the SCDDSN Level of Care Certification Letter and will mail the Certification Letter, with the procedures for reconsideration and appeals, to the participant/legal guardian and a copy to the SC/EI. All documentation regarding this decision must be maintained in the participant’s file.

Note: If a consumer no longer meets ICF/IID Level of Care, then he/she can no longer participate in the ID/RD Waiver and the SC/EI must initiate procedures for waiver disenrollment immediately (see Chapter 7 for instructions).

If the current Level of Care certification expires, and consequently, the consumer must be disenrolled from the waiver while the Consumer Assessment Team is reviewing a determination that found him/her to no longer meet ICF/IID Level of Care, his/her waiver-funded authorizations must be terminated immediately; however, the services will continue under state funds during the Consumer Assessment Team’s review.

If the participant is found to not meet ICF/IID Level of Care, and the Consumer Assessment Team does not concur with the decision, the decision will be overruled. The Consumer Assessment Team will signify their disagreement with the decision by completing a new Level of Care Determination for ICF/IID and SCDDSN Level of Care Certification Letter and returning it to the SC/EI. All documentation of this decision must be maintained in the participant’s file.

Note: If the eligibility of a consumer enrolled in the ID/RD Waiver changes to a non-eligibility status for Intellectual disability or Related Disability, the SC/EI must complete a Level of Care Re-evaluation which is warranted anytime a consumer’s condition changes. Given this new eligibility information, the consumer would not meet Level of Care since Level of Care requires a diagnosis of Intellectual disability or Related Disability. Therefore, the SC/EI must submit the adverse Level of Care to the Consumer Assessment Team. **A participant cannot be disenrolled from the ID/RD Waiver solely based on an eligibility decision. A Level of Care re-evaluation must be done and this decision upheld by SCDDSN through the SCDDSN Reconsideration process. If the participant then files an appeal with SCDHHS, Division of Appeals and Hearings, and the LOC Re-evaluation decision is upheld, then the participant can be disenrolled from the ID/RD Waiver.**

South Carolina Department of Disabilities and Special Needs Consumer Assessment Team

Request for ICF/IID Level of Care (ID/RD Waiver)

Date: _____

Consumer: _____

Consumer's Address: _____

County of Residence: _____

Medicaid #: _____

SSN#: _____

Board/Provider: _____

Dist. Office Rep/QMRP:
(for ICF/IID consumers)

SC/EI and phone #: _____

SC/EI E-mail address: _____

LOC Request

- ☐ Initial LOC (First time sent to CAT)
☐ Initial LOC (Consumer Disenrolled/Seeking to re-enter the ID/RD Waiver)
☐ Initial LOC (expired)

☐ Enrollment did not occur within 30 days of LOC effective date

OR

☐ Over 365 days old
 Copy of last LOC dated _____ (Included with packet)

- ☐ Annual Re-evaluation for time limited eligibility only
 Waiver Enrollment date: _____
 Time Limited eligibility expiration date: _____
 Copy of last LOC dated _____ (Included with packet)

- ☐ Found to not meet ICF/IID LOC by the DSN Board/Provider

Eligibility Category

- ☐ Intellectual disability
☐ Related Disability _____ Specify
☐ High Risk Infant/At Risk Child
☐ Spinal Cord Injury
☐ Head Injury
☐ Similar Disability _____ Specify

Waiver Enrollment Information (for ID/RD only)

Has this person been institutionalized? ☐ Yes ☐ No

Did this person begin waiver services immediately following move from ICF/IID? ☐ Yes ☐ No

Date Freedom of Choice (ID/RD Form 1) signed: _____

TO BE COMPLETED BY CAT LOCATED AT THE MIDLANDS FIELD OFFICE

Level of Care Effective Date: _____ ☐ Found to not meet ICF/IID Level of Care

SC, EI, QMRP, or District Office Rep
ID/RD Form 9 (08/13)

Service Coordinator/Early Intervention Supervisor

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**LEVEL OF CARE****CERTIFICATION LETTER**

TO: _____ COUNTY OF RESIDENCE _____

SS#: _____ MEDICAID # _____

LOCATION OF ASSESSMENT: _____

The South Carolina Department of Disabilities and Special Needs has evaluated the information submitted by your physician and other professionals and has determined that:

- () according to Medicaid criteria, you do not meet medical requirements for Intermediate Care for the Individuals with Intellectual Disability. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility.
- () according to present Medicaid criteria, you meet requirements to receive long term care at the following level:
- () Intermediate Care Level for Individuals with Intellectual Disability

This letter must be presented to the facility to which you are admitted.

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

If you disagree with this determination, please read the reverse side of this notification.

EFFECTIVE DATE: _____ EXPIRATION DATE _____

SIGNATURE/TITLE_____
DATE OF ASSESSMENT

SCDDSN RECONSIDERATION AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability/Related Disabilities (ID/RD) Waiver, the Pervasive Developmental Disorder (PDD), the Community Supports Waiver (CSW) and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to:

State Director
SCDDSN
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, the representative or the person assisting the participant in filing the request. If necessary, staff will assist the participant in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to appeal to the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach a copy of the written reconsideration notification received from the SCDDSN regarding the specific matter that is the subject of the appeal. In the appeal request, the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

LEVEL OF CARE DETERMINATION FOR ICF/IID

NAME _____ ID _____ DOB _____

1. Person has: (at least one of the following)

a) Intellectual Disability: _____ Yes _____ No

b) Related Disabilities: _____ Yes _____ No

Based upon the following assessment(s), copies of which are found in the client record:

Date**AND**

2. Supervision is necessary due to: (at least one of the following)

Impaired judgment/limited capabilities _____ Yes _____ No

Behavior problems _____ Yes _____ No

Abusiveness _____ Yes _____ No

Assaultiveness _____ Yes _____ No

Drug effects/medical monitorship _____ Yes _____ No

Based upon the following assessment(s), copies of which are found in the client record:

Date**AND**

3. Services are needed for: (at least one of the following)

a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No

b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which are found in the client record:

Date**APPROVED FOR ICF/IID LEVEL OF CARE**

_____ Yes _____ No

_____ Initial Determination

_____ Annual Recertification

_____ Other (specify)

Signature/Title_____
Date

(revised 8/2013)

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEVEL OF CARE EVALUATION****STAFFING REPORT**

Consumer's Name: _____

Social Security #: _____

The above named consumer has been determined by the Office of Consumer Assessment to

☐ meet☐ not meet

the Medicaid Level of Care criteria for ICF/IID.

Team Member Signatures:

Physician Signature and Date:

Evaluation Date: _____